DOD Policy:
Medical
Retention

COMMANDERS DIGEST

VOL. 15, NO. 2/JANUARY 10, 1974

Health Care in the All-Volunteer Force – pg. 2

U.S. Air Force Photo by Dana Shelton

An Air Force surgical team prepares a patient for surgery at Malcolm Grow USAF Medical Center, Maryland.

In All-Volunteer Environment

Military Departments Must Provide Top Health Services

By
Dr. Richard S. Wilbur
Former Assistant Secretary of Defense, (Health and Environment)

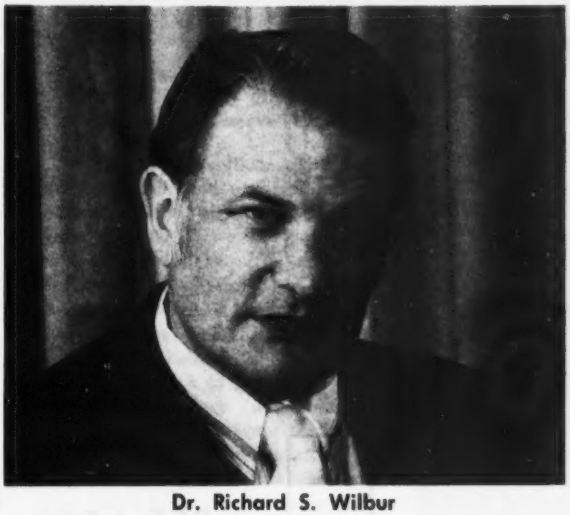
The overall purpose of [legislation before Congress] S. 2770 is to ensure a level of military physician staffing in an All-Volunteer environment that will enable the military medical departments to continue to provide adequate health services for our Armed Forces.

More specifically, the bill would amend existing law—which was first enacted in 1947—so that a military physician would be entitled to the maximum physician special pay of $350 per month after he completes two years of active duty, instead of after 10 years of such duty as required by present law.

S. 2770 would also authorize the military departments, under regulations prescribed by the Secretary of Defense and approved by the President, to pay a bonus to a military physician up to $15,000 for each year that the officer served on active duty under a Service agreement. Under the bill, a bonus could be paid in annual, semiannual or monthly installments, or in a lump sum after completion of the period of active duty specified in the agreement.

Without this bill, there will soon not be enough military physicians on active

Dr. Richard S. Wilbur Speaks Before Senate Armed Services Committee



Dr. Richard S. Wilbur

Former Assistant Secretary of Defense (Health and Environment) Dr. Richard S. Wilbur testified before Congress in mid-December about legislation to support an All-Volunteer Force in the medical professions.

Dr. Wilbur, who stayed on with DoD in a consultant's role following his September resignation, was the primary witness in December 14 hearings before the Senate Armed Services Committee. The committee was considering the bill (S. 2770) to "amend chapter 5 of title 37, United States Code, to revise the special pay structure relating to medical officers of the uniformed services."

Dr. Wilbur noted that the concepts reflected in this legislation were developed while he served as the Assistant Secretary for Health and Environment.

He was accompanied by Maj. Gen. George J. Hayes, Principal Deputy Assistant Secretary of Defense (Health and Environment) and by the three Surgeons General of the Armed Forces; Lt. Gen. Richard R. Taylor, U.S. Army; VADM Donald L. Custis, U.S. Navy; Lt. Gen. Robert A. Patterson, U.S. Air Force.

duty to support deployed field units and simultaneously to provide health care in our fixed medical facilities. In essence, without this or similar legislation, the ability of the military medical services to carry out their primary mission of planning, preparing for and providing medical support for military operations will be seriously impaired.

S. 2770 would in no way affect the currently authorized pay and allowances of any health professionals other than physicians. While we do have procurement and retention problems with respect to certain other health professionals such as dentists, veterinarians, optometrists, clinical psychologists and podiatrists, the problems in question are not as severe as those we are experiencing in relation to physicians; consequently, we have not included them in this proposal.

All-Volunteer Force Need

We believe that the enactment of this bill is essential to the achievement of our All-Volunteer goals. Its enactment would provide the Department of Defense with a flexible management tool with which to procure an All-Volunteer Force of physicians that, in turn, would enable us to give the quality of care that can best be given by professionals who are voluntarily performing their duties.

Medical Pay Gap

The problem that S. 2770 seeks to overcome is the vast disparity between the earnings of young military physicians and young civilian physicians. For example, under our present pay tables, a young military physician who has been practicing for five years receives total pay and allowances, including his tax advantage, amounting to $20,000 per year. The median income of civilian physicians in their fifth year of practice is $43,000, which results in a gap of $23,000. By the 10th year of practice the gap has narrowed somewhat, with military earnings amounting to $29,000 and the median civilian income totaling $45,000—a gap of $16,000. Approximately 10 years later the gap is narrowed down to $4,000.

Since the primary purpose of this proposed legislation is to narrow the gaps I have described, our implementation plans provide for giving the largest pay increases to the young physician, smaller pay increases to those in their midpractice years, and virtually no pay increases for those beyond the lieutenant colonel/commander level. While you may have observed some tables related to this proposed legislation which do reflect bonuses of significant sizes for those in the higher grades, the amounts in question are designed simply to equal the continuation pay which such officers have received since 1967, but which would be discontinued under this proposed legislation. Thus, the amounts of their bonuses will, in effect, be "save pay" provisions rather than pay raises.

This committee (Senate Armed Services Committee) is well aware of the difficulties involved in procuring physi-

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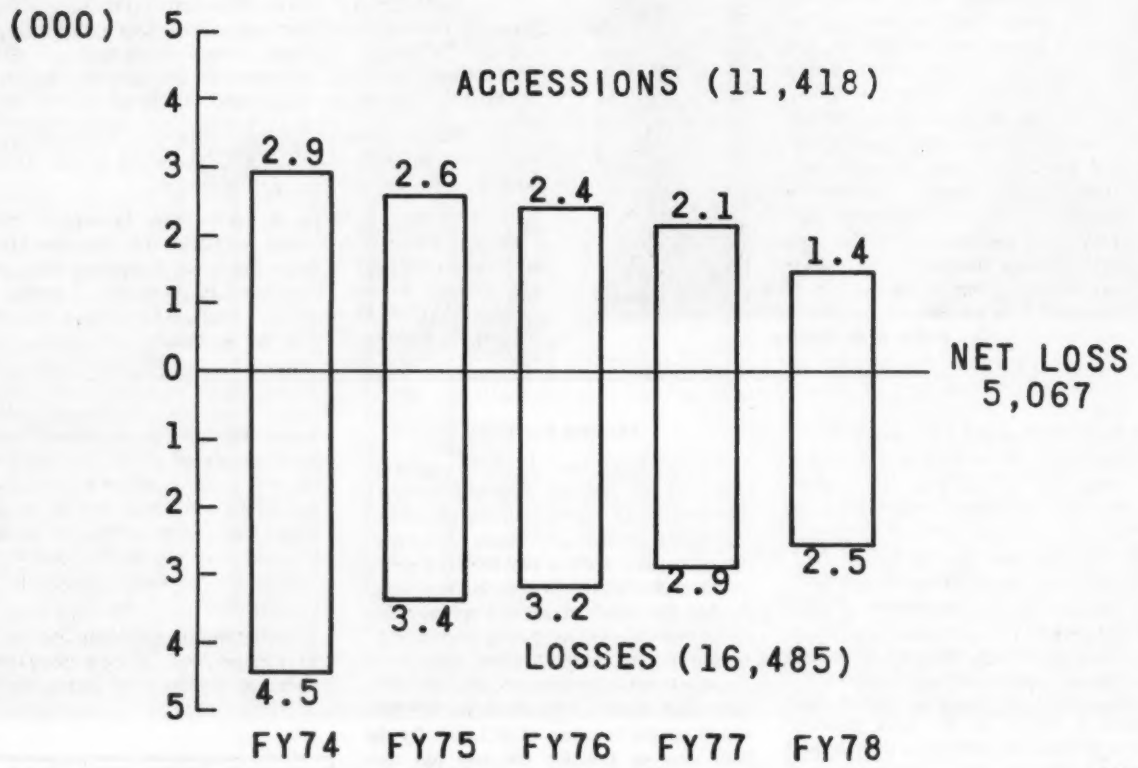

Chart I

cians to serve on active duty on a voluntary basis. The Armed Forces have not been able to meet their requirements for military physicians with volunteers since September 1940. Many factors have contributed to this 33-year inability, and we are addressing all of them by one means or another.

Physician Retention

At present, only one-sixth of the physicians on active duty are serving voluntarily. Another one-sixth serve because of obligations incurred through DoD-subsidized military training programs. The remaining two-thirds serve because of the doctor draft. Since drafted or draft-motivated physicians serve only two years, one-third of our physician force has turned over each year. Although the draft ended last summer, those who entered under the draft's impetus in the summer of 1972 will be leaving us next summer, and those who entered on active duty under the impetus of the draft this past summer will complete their military service in the summer of 1975. Thus, even though the draft is ended, it still provides the bulk of our military physician force.

I would now like to invite the committees attention to a series of charts which have been placed before you on the table. Chart I shows the projected gains and losses for DoD physicians through Fiscal Year 1978:

- Gains will total 11,418.
- Losses will total 16,485.
- The net loss will be 5,067.

Chart II reflects the projected staffing of DoD physicians through Fiscal Year 1978:

- For FY 1975 the authorization is 12,174. The projected on-board strength will be 10,335. This will result in 85 percent staffing.
- For FY 1978 the on-board strength is projected at 8,574. This will result in 68 percent staffing.

Assistant Secretary of Defense Brehm Stresses Medical Retention

By
William K. Brehm
Assistant Secretary of Defense
(Manpower & Reserve Affairs)

Of the various officer specialties in the health field required in the Armed Forces, physicians are the most critical. If we are to retain and attract the required numbers and quality of physicians in an All-Volunteer Force, additional financial incentives must be provided. We do not believe it feasible or deisrable to seek to match the economic alternatives available to physicians in the private sector of our economy, but we do believe it is essential to narrow the gap that now exists between the compensation of physicians in the Armed Forces and those in the private sector.

The proposed Uniformed Services Special Pay Act previously submitted to the Congress would have provided discretionary authority for extra pay not only for physicians but also for other categories of officers in the health field. Since the most immediate and critical problem is with physicians; and since it is only the latter group where significant pay disparities exist in comparison to average civilian economic opportunities, we believe priority action at this time can be limited to the physician problem. The possible need for additional compensation for the other categories of officers in the health fields will be kept under close and continuing review. Appropriate recommendations will be submitted to the Congress at a later date if found essential.

William K. Brehm
Assistant Secretary of Defense
(Manpower & Reserve Affairs)

Even with accessions from the Berry Plan and other procurement sources, and reductions in Medical Corps authorizations, we expect shortages of military physicians by the end of FY 1974, with substantial increases in the amount of shortages projected for FY 1975 and FY 1976.

The solution is to decrease our requirements and provide a program of incentives which will attract and retain volunteers. P.L. 92-426 authorizes the establishment of the Uniformed Services University of the Health Sciences and the Armed Forces Health Professions Scholarship Program, which will assist in easing the shortage of physicians in the long run. The financial incentives to be provided by the proposed legislation should allow attainment of physician procurement requirements in the immediate future. We believe it is essential that this legislation be enacted so that the shortage of physicians will not adversely affect the health care provided our military personnel and other beneficiaries.

The projected staffing shortages for physicians will have a serious impact on the ability of the military medical services to provide contingency support.

Military Family Needs

Adequate medical care for the active duty member and his family is a valuable incentive to the married volunteer. Any degradation in the amount or quality of medical care provided to military personnel and their families will be counterproductive to the All-Volunteer Force concept.

Physician retention may be even less than is projected on these charts unless the loss trend is quickly reversed. With reduced staffing, we will be required to curtail health care to many beneficiaries, first, for retired members and their families and, secondly, for active duty dependents. If care is curtailed, the breadth of medical diagnostic problems among patients diminishes. The resulting lack of diversified patient material would place our accredited specialty training programs

Asst. Secretaries of Defense Positions Defined

A sentence in Commanders Digest, Vol. 14, No. 25, December 20, 1973 "DoD Organization and Mission" contained incorrect information. The article on page 6, paragraph 5, should have read: "The positions of the Director of Defense Research and Engineering and the General Counsel are specifically provided for by law. The law also makes provisions for nine positions as assistant secretaries of Defense of which one shall be the Assistant Secretary of Defense (Health and Environment), one shall be the Assistant Secretary of Defense (Manpower and Reserve Affairs), and one shall be the Assistant Secretary of Defense (Comptroller)."

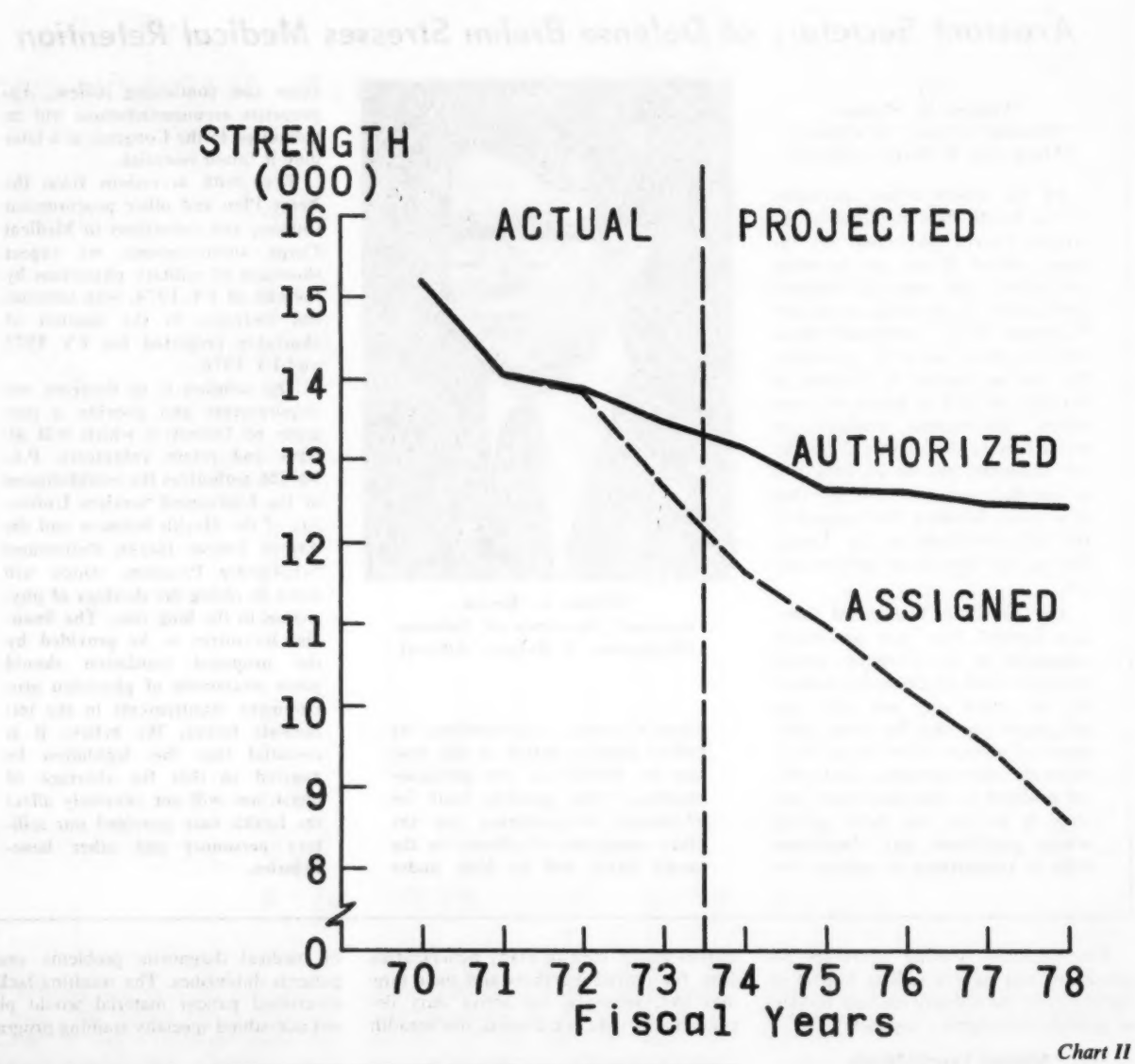

Chart II

for young physicians in jeopardy. These training programs have been our most valuable retention device. We would not be able to retain physicians without them. This degradation of training capability will not start in 1976 or 1978—it has already begun as a result of losses among senior physicians who conduct our specialty training programs.

Based on a recent survey of DoD physicians, we estimate that 10 percent of those now performing their obligated service will leave us when their obligations are completed, regardless of the incentives offered. Thus, the target group for our proposed incentives is the remaining 90 percent of our projected losses. Our potential for career gains are:

- FY 1974 1,323
- FY 1975 3,051
- FY 1976 2,875

The retention of one out of three of this potential would solve our FY 1976-FY 1980 staffing problems.

If we are to have an effective military health care service, we need a pay system for military physicians that will neutralize the strong magnetic effect of high civilian earnings potential. We need a pay system that will assist us in efforts to recruit some young practitioners from civilian life, retain a large portion of those who complete their initial obligation, and retain some experienced health professionals for a full military career. We need a pay system for military physicians that

DOCTORS—The first physician-astronaut, Navy Medical Corps Capt. Joe Kerwin, talks with the Navy's first lady physician Lt. Jane O. McWilliams. Dr. McWilliams was recruited from civilian life for flight surgeon training and completed her special training at the Naval Aerospace Medical Institute, Pensacola, Florida, in late December.

U.S. Navy Photo

meets the same standard as the general military pay system does for most other occupations—one that is reasonably competitive with similarly qualified individuals in the civilian sector. We chose the bonus approach because we concluded that it would give us the strongest flexibility to pay the amounts necessary to meet our requirements.

Medical Pay Proposal

The net additional cost of our medical pay proposals, with an estimated first year cost of $50.7 million, will rise to $77.4 million by Fiscal Year 1978. The additional budget costs reflect the elimination of continuation pay for Medical Corps officers. If the pay increases covered by S. 2770 and other administrative actions that we plan are successful, thus enabling us to achieve an All-Volunteer physician force, it is possible that reductions in strengths of Medical Corps officers and related personnel costs would result in additional offsetting savings.

It is our opinion that the provisions of S. 2770 represent the soundest approach for overcoming competition from civilian earnings for members of the medical profession. We are not proposing that we attempt to "buy" doctors from civilian practice. Rather, we are recommending measures that will remove the disincentive of relatively inadequate military pay and that will provide the necessary at-

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Surgeon General,
U.S. Army

VADM D. L. Custis, USN
Surgeon General,
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Lt. Gen. R. A. Patterson, USAF
Surgeon General,
U.S. Air Force

tractions for retaining physicians beyond their initial obligated terms of service. The provisions of S. 2770 complement the other elements of our action program to the end that quality care will continue to be available to our Armed Forces. Military physicians will be adequately compensated, but with salaries that do not add to the present inflationary pressures within the health care industry.

Current Medical Scholarships

A year ago this committee approved the first legislation designed to help us achieve an All-Volunteer health force. I am referring to Public Law 92-426 which created the Armed Forces Health Professions Scholarship Program and the Uniformed Services University of the Health Sciences. Both of these programs are vital parts of our overall All-Volunteer Force plans. However, we will not realize the full benefits from these two programs for another eight to ten years. S. 2770 is intended to fill the gap between now and the early 1980s when our two main sources of career procurement will consist of the scholarship and university program outputs.

I strongly urge favorable action on S. 2770.

U.S. Navy Photo

The National Naval Medical Center, Bethesda, Maryland, is a typical, modern military hospital.

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